

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

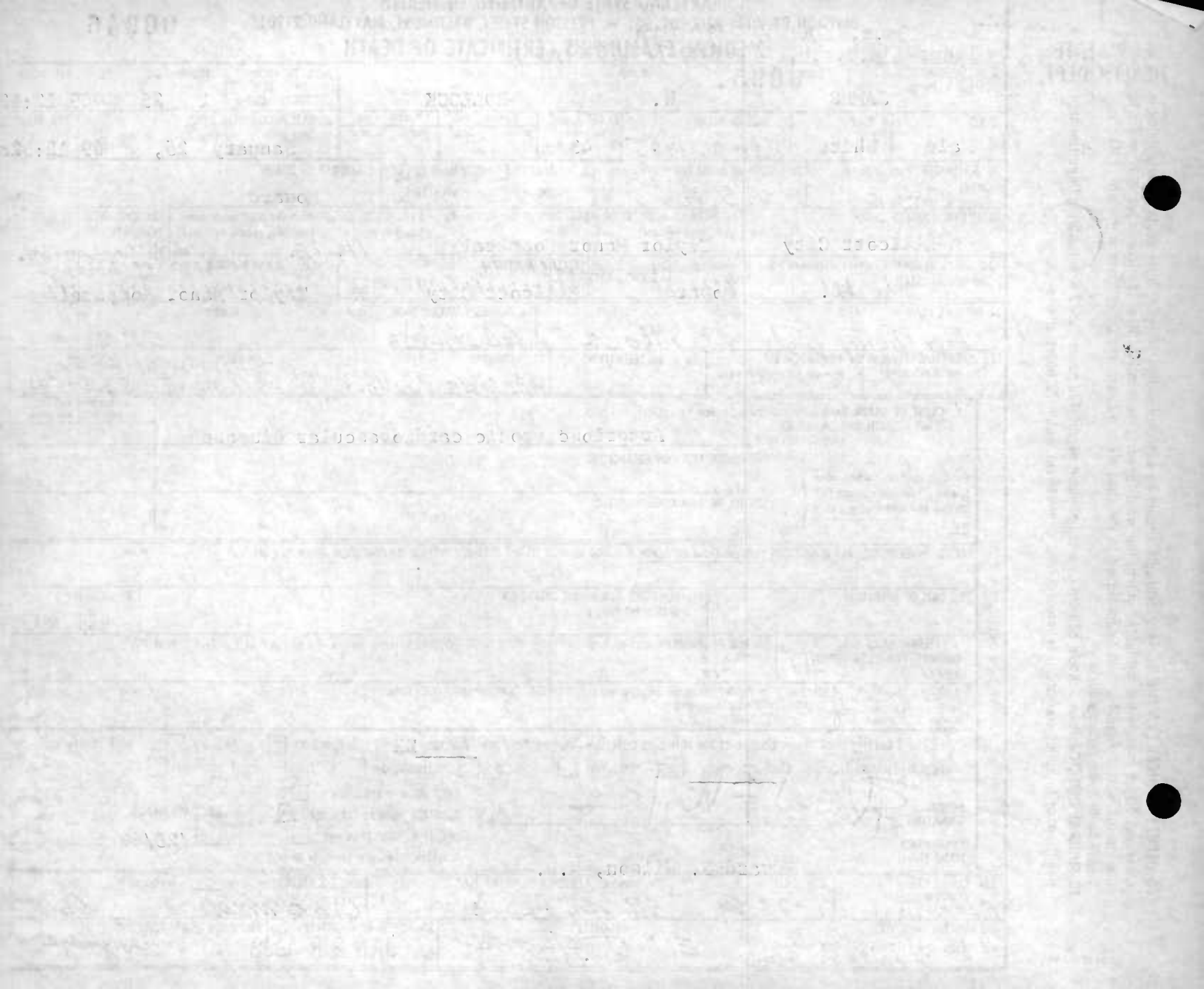
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items#13e,c,e, Filing#40977/1/69

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00946

1. DECEASED-NAME (Type or Print)		First Middle Last		2a. DATE KNOWN OF DEATH		Month Day Year		2b. HOUR	
JAMES		W. BULLOCK		Month Day Year		1 25 1969		12:32	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	Feb 26 1925	43 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
Ohio		U.S.A.				Howard		12:30a	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Ellicott City		Taylor Manor Hospital		None		3601 Center St.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Ohio		Howard		Ellicott City				6958 Miami Bluff Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Anthony D. Bullock		Adelaide						Adelaide Bullock	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
		19						21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City or Town) (County) (State)	
Edward F. Wilson, M.D.				1/25/69		Spring Grove		Cincinnati Ohio	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR	
Cremated		1-27-69		Spring Grove		Cincinnati Ohio		DATE JAN 28 1969	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	
Higinbotham-Slack		Ellicott City, Md.		Charles Judge					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00952

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00947

1. DECEASED-NAME (Type or Print) DAVID			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month Day Year Jan. 19, 1969			2b. HOUR 11:20		
3. SEX Male		4. RACE White		5. DATE OF BIRTH SEPT 16, 1948		6. AGE (In years last birthday) 20 YRS. MONTHS 4 DAYS 3		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) MD Baltimore			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 180 Montgomery Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 180 Montgomery Rd.		
14. FATHER'S NAME JEROME			First Middle Last			15. MOTHER'S MAIDEN NAME TRUTH			First Middle Last DEBERRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. NONE			17. INFORMANT JEROME CARLIN			ADDRESS 180 Montgomery Rd. Ellicott City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Interstitial Pneumonitis IMMEDIATE CAUSE (a) 484X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 1/20/69			
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-22-69			23c. NAME OF CEMETERY OR CREMATORY Woodlawn			23d. LOCATION (City or Town) (County) (State) Woodlawn BALTO MD.		
24. FUNERAL DIRECTOR Higinbotham SLACK						ADDRESS Ellicott City Md.			25a. REC'D BY REGISTRAR DATE 22 1969		
						25b. REGISTRAR'S SIGNATURE Charles J. J...					

0088

RECEIVED
OFFICE OF THE
DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

0088

OFFICE OF THE
DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

1

0088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00
13
1

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Ruth Agnes Dennis			2a. DATE OF DEATH Month January Day 3 Year 1969			2b. HOUR 9:4 M				
3. SEX female		4. RACE white		5. DATE OF BIRTH March 12 1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard Md.				
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 144 Montgomery Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 144 Montgomery Rd.	
14. FATHER'S NAME First John Middle Baer Last Baer			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212 36 8031		17. INFORMANT Lewis H. Dennis Address 144 Montgomery Rd, Ellicott City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, general cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) auricular fibrillation since 1966 DUE TO, OR AS A CONSEQUENCE OF (c) Patient died in sleep. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1-4-67 , 19____, to 1-3-69 , 19____, that (I) (we) lost the deceased alive on 12-31-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert B Taylor MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-4-69			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/6/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION (City or Town) (County) (State) Elkridge Howard Md.				
24. FUNERAL DIRECTOR Higinbotham Slack					ADDRESS Ellicott City, Md.		25a. REC'D BY REGISTRAR DATE 1 AM 7 1969		25b. REGISTRAR'S SIGNATURE MS. [Signature]	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00949			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print) Anna Mae Germany						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 12 Year 1969			2b. HOUR M						
3. SEX Female		4. RACE colored		5. DATE OF BIRTH July 21 1929		6. AGE (In years last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 		2c. DATE PRONOUNCED DEAD Month Jan Day 12 Year 1969		2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Howard				Md.		
10. CITY OR TOWN OF DEATH Jessup				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 82A Rt#1				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Howard		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 82A Rt#1					
14. FATHER'S NAME First Joseph Middle Last MARTIN						15. MOTHER'S MAIDEN NAME First ANNA Middle Mae Last Mitchel									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 340X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Donald E. Fisher M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 1/12/69					
EXAMINER'S NAME (Type) Donald E. Fisher M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or County) Ellicott City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-16-1969		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				23d. LOCATION (City or Town) (County) (State) Laurel, Prince Georges, Md.							
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville Md.						25a. REC'D BY REGISTRAR JAN 15 1969				25b. REGISTRAR'S SIGNATURE [Signature]					

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00955					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00950				
1. PLACE OF DEATH o. COUNTY <u>Howard County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Howard</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 Pinewick Road</u>					d. STREET ADDRESS <u>1803 E. 28th St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Irene Marie KNOCHE</u>					4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1969</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1902.</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>? Ballbah</u>					14. MOTHER'S MAIDEN NAME <u>Mary Deal</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-01-8319</u>		17. INFORMANT <u>Dr. William L. Knoche</u> , Address <u>10334 Malcolm Circle Cockeysville, Md.</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4109</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>1-7-69</u>				
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>44 Church Rd Ellicott City</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/9/69.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>						

1820

Sept. 10, 1882.

Sept. 10, 1882.

1820

1820

1820

1820

1820

1820-1821

1820

1820

1820

1820

1820

1820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00956			Item 11 Film 09 1/29/69 kk			00951			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
VIOLA			PAULINE			LYLES			JAN 13 1969 538 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		NEGRO		6-23-1910		58 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MD		U.S.A.				HOWARD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last year, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
DAYTON			Howard Road			UNEMPLOYED			NONE
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD			HOWARD			DAYTON		HOWARD RD.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
WILLIAM HENRY LYLES			ANNIE R. THOMAS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
NO						MRS INEZ BAILEY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									1 MONTH
IMMEDIATE CAUSE (a) <u>CACHEXIA</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>218X</u>									
(b) <u>CHR. INTESTINAL OBSTRUCTION DUE TO</u>									1 YEAR
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>LARGE UTERINE FIBROID</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>COMPLETE CONSENSUAL MENTAL RETARDATION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13, 1966</u> , to <u>1/13, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Charles S Whitaker, M.D.		1/13/69		CHARLES S WHITAKER, M.D.					
22e. ADDRESS		22f. ADDRESS							
CLARKSVILLE, MD		CLARKSVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1-17-69		BROWN'S CHAPEL CEM.		DAYTON HOWARD MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden		Rockville Md		JAN 20 1969		Charles J. J. J.			

10001

RECEIVED 10 10 1960

MAIL

STOCK

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

25

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00957										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00952									
Item 13 Film 408 1/17/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First REBECCA					Middle H					Last NEVITT					2a. DATE OF DEATH					2b. HOUR				
															1					Month 7 Day 69 Year					1345A M				
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost 83 day)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
FEMALE					WHITE					MAY 2, 1885																			
7a. BIRTHPLACE (State or foreign)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
NORTH CAROLINA					U.S.										HOWARD COUNTY										Md.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
ELLICOTT CITY, MD.					TAYLOR MANOR HOSPITAL																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission: State)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
MARYLAND					HOWARD					ELLICOTT					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					ELLICOTT CITY, MD., 21043									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Archibald Henderson					Alice Johnson																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
no										D. C. Nevitt					1116 Darlene Rd. Forest Hill, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SENILITY 794X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1957 , to JANUARY 7, 1969 , that (I) (we) last saw the deceased alive on JANUARY 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE										ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.					22c. DATE SIGNED				
Irving J. Taylor M.D.																				1/7/69									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
IRVING J. TAYLOR, M.D.										TAYLOR MANOR HOSPITAL, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					1-9-69					Pohick Church Cemetery					Laton Fairfax Va.														
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Everly-Wheatley Funeral Home										1500 W. Braddock Rd., Alex.										JAN 13 1969					Wanda Judge				

04323

RECEIPT OF PAID

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931



1931

1931

1931

1931

1931

1931

1931

1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/paper, page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00953			DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			00953			
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Ethel A. Peddicord						Jan. 23 1969			7 15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Dec. 8, 1888		80 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Md.		U.S.				Howard County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Ellicott City		Bethany Lane & Route 99							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Howard		Ellicott City				Bethany Lane & Route 99	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Charles						Emily Eugenia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
no					Miss Florence Peddicord, Ellicott City, Md.				Bethany La. & Rt. 99
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Generalized Cascinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 M 6 M	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital), attended the deceased from 3-20, 1957, to 1-23, 1969, that (I) (we) last saw the deceased alive on 1-21, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Peter V. Thorpe							1-24-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Peter V. Thorpe		S. St. Johns Lane, Ellicott City, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 25, 1969		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry H. Witzke		321 Columbia Pike, Ellicott City, Md.		JAN 27 1969		Charles Judge			

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>1/29/69</div> <div>00953</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00954</div>										
1. DECEASED-NAME (Type or Print)						2a. DATE KNOWN <input type="checkbox"/> Month Day Year		2b. HOUR		
John F. Roache						OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 1 14 1969		M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR		
male	white	11/30/1890	78 YRS.			Jan 14 1969		M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Howard Md.				
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Ellicott City			96 Fels Ave.			Coast Guard		retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER	
Md.			Howard		Ellicott City				96 Fels Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
UNKNOWN			UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
yes			W.W.1		103 Fels Ave, Mrs. Mary Winkles Ellicott City, Md. 21042					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>										
4124 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2d. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Thomas F. Herbert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Thomas F. Herbert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1-14-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		1/17/69		Good Shepherd		Ellicott City, Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Higinbotham Slack				Ellicott City, Md.		JAN 22 1969				

3300

1950-1951

1952-1953

1954-1955

1956-1957

1

1958-1959

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10&22a File 410 MARYLAND STATE DEPARTMENT OF HEALTH 3-19-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00955

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>			Month Day Year			2b. HOUR							
RANDOLPH			SKIPPER			1 15 19 69			9:00										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR				
Male		White		Jan. 11, 1969		— YRS.		4				January 15 19 69			9:00				
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH							
Md				U.S.A.								Howard				Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Ellicott City				Box 8456 Horseshoe Rd.															
13a. USUAL RESIDENCE (Where deceased lived admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER			
Md.				Howard				Ellicott				YES <input type="checkbox"/> NO <input type="checkbox"/>				Box 8456 Horseshoe Rd.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last															
UNKNOWN				VIOLET KATHLEEN PEUGH															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
No								NONE				Violet Peugh Ellicott City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> 7469 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				1/15/69							
Edward F. Wilson, M.D.				ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				1-16-69				Good Shepherd				Ellicott City Md.							
24. FUNERAL DIRECTOR				ADDRESS				25a. RECEIVED BY REGISTRAR				25b. RECEIVED BY JUDGE							
Higginbotham-Slack Ellicott City Md.								JAN 22 1969											

THE UNIVERSITY OF CHICAGO PRESS
CHICAGO, ILL. 60637

00000

LIBRARY OF THE UNIVERSITY OF CHICAGO

FOR THE
LIBRARY

DATE	DESCRIPTION	AMOUNT
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

JAN 2 1981

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													00956
1. DECEASED-NAME (Type or Print) First Middle Last ROBERT LEE STEVENS, Jr.						2a. DATE KNOWN OF DEATH Month Day Year 1-8 1969			2b. HOUR 5:35 PM				
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/24/30	6. AGE (In years last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year January 8, 1969			2d. HOUR 5:35 PM				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD Md.							
10. CITY OR TOWN OF DEATH JESSUP		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PERKINS STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Tender			12b. KIND OF BUSINESS OR INDUSTRY Paper Board					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY HOWARD		13c. CITY OR TOWN JESSUP		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 230 A PERKINS STATE HOSPITAL					
14. FATHER'S NAME First Middle Last Robert Lee Stevens, Sr.				15. MOTHER'S MAIDEN NAME First Middle Last Georgette Ashburn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) Korean		16b. SOCIAL SECURITY NO. 214 26 2954		17. INFORMANT Mrs. Georgette Stevens			ADDRESS Balto., Md. William St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive old myocardial infarcts and congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED January 9, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.							
24. FUNERAL DIRECTOR JOHN F. DENNY, INC.				ADDRESS 715 Light St.		25a. REC'D BY REGISTRAR DAN 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

